

IN THIS ISSUE:

- **VERNON HADDEN V. UNITED STATES OF AMERICA**
- **WCMSA PORTAL**
- **LIFE EXPECTANCY TABLE**
- **MSPRC TRANSITION TO NEW ACCOUNTING SYSTEM**
- **FIXED PERCENTAGE FOR MEDICARE' RECOVERY PROCESS**
- **MSPRC SELF-SERVICE INFORMATION FEATURE**

VERNON HADDEN V. UNITED STATES OF AMERICA

VERNON HADDEN, Plaintiff-Appellant, v. UNITED STATES OF AMERICA, Defendant-Appellee
UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

October 13, 2010, Argued; November 21, 2011, Decided and Filed

OPINION

[**2] KETHLEDGE, Circuit Judge. The statute that governs an issue is usually the one to rely upon in arguing it. Here, the parties agree that the Medicare [*2] statute governs the extent to which Vernon Hadden is obligated to reimburse Medicare for certain expenses that it paid on his behalf. Most of Hadden's arguments, however, concern different statutes with different language than the Medicare provision that applies here. The district court thought those arguments were beside the point. So do we; and we otherwise think that the Medicare statute itself requires Hadden to reimburse Medicare to the full extent that the government advocates. We therefore affirm the judgment of the district court.

Vernon Hadden, Plaintiff, was struck by a vehicle in August 2004. The vehicle was owned by Pennyrile Rural Electric Cooperative Corporation. Mr. Hadden is a Medicare beneficiary. His medical bills totaled \$82,036.17, which Medicare paid in full. Mr. Hadden sued Pennyrile for all his medical expenses and other damages. Pennyrile paid Mr. Hadden \$125,000 for a full release of his claims.

Medicare must pay "promptly" per Id. § 1395y(b)(2)(B)(i) and Medicare has the right to seek reimbursement from the responsible party if the beneficiary later receives a payment directly from the responsible entity per Id. § 1395y(b)(2)(B)(ii), (iii). Pennyrile paid Mr. Hadden for medical expenses; Medicare is seeking reimbursement from Mr. Hadden for the medical bills Medicare paid. After deducting the portion for attorney's fees Mr. Hadden had to pay to obtain the settlement, see 42 C.F.R. § 411.37, Medicare determined that Mr. Hadden owed Medicare \$62,338.07. Mr. Hadden paid Medicare, under protest, the \$62,338.07. Mr. Hadden argued he should only have to pay Medicare 10% of the total medicals paid reasoning an unidentified motorist was 90% responsible for the accident and the Pennyrile driver was only responsible for 10% of the accident. Approximately \$117,000 of the settlement was for pain and suffering, not medical expenses.

The case went to the administrative law judge (ALJ). The ALJ required Mr. Hadden to reimburse Medicare the full amount. The ALJ also found that the reimbursement was not against "equity and good conscience." See 42 U.S.C. § 1395gg(c). The Medicare Appeals Council agreed with each of those findings. The ruling was appealed to the district court by Mr. Hadden. The district court remanded the case back to the Appeals Council. The Appeals Court again agreed with the ALJ's findings and the district court agreed with them as well.

All parties agree Pennyrile's settlement payment to Mr. Hadden gives rise to an obligation on his part to reimburse Medicare. But they dispute whether that obligation is limited to the \$8,000 that Mr. Hadden says represented payment for his medical expenses.

The court states, "In his claim against Pennyrile, he did not demand that it pay for only 10% of the medical expenses that he incurred as a result of his accident; he demanded that it pay for all of them. That choice has consequences--one of which is that Hadden must reimburse Medicare for those same expenses." The district court's judgment is affirmed by Circuit Judge Kethledge and District Judge Sandra S. Beckwith.

Circuit Judge, Helene White, dissenting. "Historically, Medicare was primary to all coverage except worker's compensation coverage. Gradually, Congress made other forms of medical coverage primary. With the exception of liability insurance, the basis of liability for all sources of payment primary to Medicare was contractual, and the extent of the liability was based on contract, not on the amount Medicare happened to pay." In workers' compensation, Medicare Set Asides have become standard practice for addressing Medicare's interests. This system "eliminates the risk of a future denial of Medicare benefits, and assures the parties that Medicare's interests have been reasonably considered." Judge White states: "The Court recognized the negative effect of Arkansas's policy for recovering Medicaid costs on settlements between beneficiaries and tortfeasors. The policy at issue here similarly discourages settlements and may ultimately hinder CMS's efforts to recover conditional Medicare payments." ❖

Cited Work: 2011 U.S. App. LEXIS 23289, *; 2011 FED App. 0293P (6th Cir.), **

WORKERS' COMPENSATION MEDICARE SET-ASIDE PORTAL (WCMSAP)

On November 29, 2011 The Centers for Medicare & Medicaid Services (CMS) completed its Pilot Testing of the Workers' Compensation Medicare Set-aside Portal (WCMSAP). The link to the WCMSAP application may be found under the "Related Links Outside CMS" at the bottom of the WCMSAP section page.

The Workers' Compensation Set-Aside Portal (WCMSAP) allows for the electronic receipt and tracking of Workers' Compensation Medicare Set-Aside Arrangements (WCMSAs). Attorneys, beneficiaries, claimants, insurance carriers, and WCMSA vendors use the WCMSAP to enter case information directly. The WCMSAP also provides attorneys, beneficiaries, claimants, insurance carriers, and WCMSA vendors with the ability to track their submitted cases and statuses without inquiry to COBC or CMS.

Unless previously registered, all registrants are directed to the WCMSAP URL to register for a web portal account. Users of the Mandatory Reporting application must use the same Login ID and Password to access the WCMSAP site.

From the WCMSAP registration page, the submitter will first select an account type. The submitter will then provide basic information about the account requestor and, when applicable, the beneficiary/claimant. Through the registration process, the COBC will obtain the information needed to:

- Validate information provided by the registrant
- Assign Account IDs to each WCMSAP Account
- Develop a WCMSAP Profile Report for each organization
- Obtain contact information and the mailing address for the account

WCMSAP registration and account setup is a 7-step process (the final 2 steps are for Corporate & Representative account types only):

- Step 1: Determine Account Type
- Step 2: Identify a Contact for the Account
- Step 3: Start Account Registration
- Step 4: Account Setup and Account Manager Registration
- Step 5: Return Signed Profile Report
- Step 6: Identify Account Designees
- Step 7: Account Designee Registration

Before beginning the registration process, an organization or person must determine its account type. There are three types of WCMSAP accounts: Corporate, Representative, and Self. Account types are mutually exclusive; only one may be selected.

Corporate account type indicates that the submitter is registering as a corporate entity with an Employer Identification Number (EIN). Those registering as a Corporate account will regularly submit WCMSAP requests.

Representative account type is for non-corporate WCMSAP users. These submitters do not have an EIN, but will submit multiple cases.

Self submitters are Medicare beneficiaries, or individuals with a reasonable expectation of becoming a Medicare beneficiary within 30 months, who submit cases for themselves.

The account type selected determines both the basic information that is captured during the registration process and the level of vetting that is subsequently undertaken.

Some key features of the new CMS Portal:

- The CMS Case Control Number will be immediately available upon submission.
- Submitters can easily track MSA status.
- All documentation can be uploaded directly to the portal eliminating the delays caused by mailing to the COBC.

- Submitters will receive an alert when an additional development letter or final decision has been issued.
- The portal was designed so that cases that do not meet CMS workload review thresholds cannot be submitted for review.
- Zero allocation MSA proposals and reconsideration requests can be submitted through the portal

GENEX has begun the registration process. As soon as the registration process is completed GENEX will begin submitting MSAs through the CMS Portal. ❖

FEATURES OF THE WCMSA PORTAL SITE

On the Welcome Page of the Workers' Compensation Set-Aside Web Portal (WCMSAP), you will find the following menu options:

About This Site - This option provides the purpose of the site and general information on how to use it.

CMS Links - This section provides a link to the Workers Compensation Agency Services page, and the General Medicare and Coordination of Benefits pages on the CMS Web site.

How To... - This option provides general instructions on how to get started, register, and complete account setup on the WCMSAP.

Reference Materials - This option provides links to view and download the WCMSAP User Manual.

Contact Us - This section provides information on how to contact the COBC EDI Department.



The area on the right side of the Welcome Page contains fields related to Account Login. Once you have obtained your Login ID and Password for the WCMSAP, you will enter them here and click the Login button to sign into the application. Note: Users of the Mandatory Reporting application must use the same Login ID and Password to access the WCMSAP site.

Forgot ID Link - If you already have a Login ID and Password for the WCMSAP but have forgotten the User Name you created, you may use this link to request it.

Forgot Password Link - If you already have a Login ID and Password for the WCMSAP but have forgotten your Password, use this link to reset it.

The area near the bottom of the Welcome Page contains two buttons:

Step 1 New Registration - Click this button if this is the first time you have accessed the WCMSAP to register and obtain a WCMSAP Account ID.

Step 2 Account Set Up - Click this button if you have gone through the initial registration process and have received your mailing containing your Account ID and Personal Identification Number (PIN) from the COBC. You will need the Account ID and PIN to continue with the Account Setup process.

At the bottom of the Welcome Page, there are links to the WCMSAP Privacy Policy and User Agreement. ❖

LIFE EXPECTANCY TABLE

The Centers for Disease Control (CDC) has recently published its 2007 United States Life Tables. Effective October 31, 2011, the Centers for Medicare & Medicaid Services (CMS) will begin referencing the CDC's Table 1: Life table for the total population: United States, 2007, for WCMSA life expectancy calculations. This means that for any newly submitted WCMSA proposal received by CMS' Coordination of Benefits Contractor (COBC), or where any WCMSA case is reopened on or after October 31, 2011, CMS will apply the CDC's 2007 Table 1 for life expectancy calculations. ❖

Cited Work: <https://www.cms.gov> Accessed: October 4, 2011

MSPRC TRANSITION TO NEW ACCOUNTING SYSTEM

Medicare Secondary Payer Recovery Contractor (MSPRC) transitioned to the Healthcare General Ledger Accounting System (HIGLAS) the week of October 13, 2011. This transition is only for the internal MSPRC financial accounting system. Group Health Plan payment and defense updates were held through the transition. Transaction posting dates are determined by the postmark date of the submission. ❖

Cited Work: <http://www.msprc.info> Accessed 10/24/11

NEW FIXED PERCENTAGE OPTION FOR MEDICARE'S RECOVERY CLAIM

The Centers for Medicare & Medicaid Services will be implementing a new and simple fixed percentage option that will be available to certain beneficiaries beginning November 7, 2011. This option is available to beneficiaries who receive certain types of liability insurance (including self-insurance) settlements of \$5000 or less.

A beneficiary who elects this option will be able to resolve Medicare's recovery claim by paying Medicare 25% of his/her total liability insurance settlement instead of using the traditional recovery process. This means that a beneficiary will know what he/she owes and will be able to immediately pay Medicare.

In order to elect this option, the following criteria must be met:

1. The liability insurance (including self-insurance) settlement is for a physical trauma based injury. (This means that it does not relate to ingestion, exposure, or medical implant), and
2. The total liability settlement, judgment, award, or other payment is \$5000 or less, and
3. The beneficiary elects the option within the required timeframe and Medicare has not issued a demand letter or other request for reimbursement related to the incident, and

4. The beneficiary has not received and does not expect to receive any other settlements, judgments, awards, or other payments related to the incident.

A full explanation, including instructions on how and when to elect this option, will be available on this website on November 7, 2011 in the Fixed Percentage Option section of both the Attorney and Beneficiary Toolkits.

Please Note: When a beneficiary elects this option, he/she must understand that as part of choosing the option he/she will be giving up the right to appeal the fixed payment amount or request a waiver of recovery for the fixed payment amount. ❖

Cited Work: <http://www.msprc.info> Accessed 10/25/11

THE MSPRC SELF-SERVICE INFORMATION FEATURE

On October 21, 2011, Medicare Secondary Payer Recovery Contractor (MSPRC) added a Self-Service Information feature to its Customer Service Line. This feature gives the callers the ability to get the most up-to-date Demand and Conditional Payment amounts as well as the dates those letters were issued without having to speak to a Customer Service Representative.

Some of the new features:

- Extended calling hours (24 hours/day – 7 days/week)
- No wait time
- Unlimited number of cases inquiries on one phone call

Information required from the caller:

- Case identification number
- Beneficiary's date of birth
- First five letters of the Beneficiary's last name
- Last 4 digits of the Beneficiary's Social Security number or full Medicare number. ❖

Cited Work: <http://www.msprc.info> Accessed 10/27/11